

City of Manchester Plan Document and Summary Plan Description

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This document and the contracts for each of the Benefit Plans covered hereunder (the “Contracts”) together constitute the plan document and Summary Plan Description for the City of Manchester Health & Welfare Plan (the “Plan”). The City of Manchester is a municipality and therefore the Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) rules and regulations that govern most benefit plans. The Plan is an “employee welfare benefit plan,” and in part, a “cafeteria plan” under the Internal Revenue Code of 1986, as amended.

The Plan is self-funded, follows applicable Federal laws and is exempt from benefits mandated by State law.

This document describes the rules for participation in the Plan. It also contains information to which you are legally entitled as a plan participant and summarizes the eligibility and Plan administration rules of the Plan. For more information about the particular benefits to which you may be entitled, please refer to those individual Contracts for details. To the extent any information contained in this document is inconsistent with the Contracts, the Contracts shall govern.

The City of Manchester (the “City”) is the plan sponsor and the plan administrator of the Plan (the “Plan Administrator”).

About Your Participation

Who is Eligible

You must be an employee of the City of Manchester or a dependent of such employee and meet the applicable eligibility requirements in order to participate in the Plan.

The documents listed in Addendum A generally will detail the eligibility and enrollment requirements for each specific type of benefit offered under this Plan. However, due to health reform, specific rules apply to health plans subject to the health reform law and regulations.

For the Plan Year in which health reform takes effect and for the future, the Plan intends to administer eligibility using current guidelines permitted under federal health reform and all health reform eligibility guidance yet to be issued. All provisions herein shall be interpreted such that the Plan shall be in compliance with those rules and guidelines. Any minor inconsistencies shall be automatically revised to be in compliance with those rules and their interpretations by the federal agencies.

To participate in the Plan, an Employee must be either:

- Designated as having Full-Time status at date of hire or in current employment files, or
- Must be Variable or Seasonal Employee as designated at date of hire or in current employment files and determined to have been working 30 hours or more per week on average over the course of an applicable benefits eligibility determination period, known as a Measurement Period.

Full-Time Employees. “Full-Time” is defined as an employee working thirty (30) or more hours a week on average in a month, which is considered to be one hundred thirty (130) hours in the course of a month.

Employees in positions who are expected or designated to be Full-Time based on expected work hours at date of hire are eligible for the Plan. Under federal law, health plan coverage will begin no later than ninety (90) days from the hire date. Other benefits’ effective dates are not impacted. From time to time, a shorter waiting period may apply or different standards for waiting periods may apply relating to (1) bona fide orientation periods for new hires, (2) required hours up to 1,200 hours for new hires, (3) hours bank requirements, and (4) such other variations to the hours or term of employment as allowed by federal law, agency interpretations, or other clarifications to the waiting period rules under federal health reform, including but not limited to as a result of court decisions.

Part-time, Variable Hour and Seasonal Employees. Employees in part-time status expected to be working less than 30 standard hours per week, with hours that will vary, and who are expected/designated to be “Variable Hour Employees” are ineligible for participation until the City of Manchester determines the eligibility based on hours actually worked or credited under the law. That determination is made following a 12-month benefit eligibility verification period, or “Measurement Period.” Similarly, Seasonal Employees will be subject to the determination of eligibility based on hours actually worked or credited under the law. A Seasonal Employee for this purpose is an individual hired for a position that is customarily filled at around the same time every calendar year and which generally is of less than 6 month’s duration. Seasonal status will be designated using processes similar to those for Variable Hour Employees.

Determination of that status and/or eligibility from 2015 and beyond will be based on current designation of employment status as full-time or on hours worked for Full-Time Employees and Variable Hour Employees, respectively, in accordance with current federal law. (Seasonal Employees will be treated similarly to Variable Hour Employees.) To the extent the City of Manchester wishes to use a federal agency interpretation of these requirements to determine hours, status, Plan eligibility, or otherwise, the City of Manchester may choose to do so to the fullest extent of the law, including special short-term rules which permit determinations of employer size and/or eligibility on the basis of period of less than a full 12 months or calendar year or Plan Year.

Two separate Measurement Periods are used for Variable Hour and Seasonal Employees, one for new hires that is specific to the date of hire of that particular Employee, and one for all other Variable Hour or Seasonal Employees (in other words, those who are not new hires).

1. **New Hire Measurement Period.** For a new hire, the New Hire Measurement Period shall be 12 months starting with the first of the month following date of hire, allowing for the person's information to be entered into employment and hours systems. Hours worked are counted beginning the first of the month following date of hire through the following 12-month period. Eligibility determinations based on calculations made for hours worked during this 12-month period will affect eligibility for the Plan for the 12-months starting with the 13th month following date of hire. In other words, if a new hire is determined to be a Full-Time Variable Hour (or Seasonal) Employee, the Employee will be eligible to participate in the Plan beginning with the first day of the 13th month following date of hire.
2. **On-Going Employee Measurement Period.** For On-going Employees (other than new hires) who work Variable Hours or who are Seasonal, the On-going Employee Measurement Period shall be 12 months from May 1st to April 30th each year. In other Plan materials or in federal publications and guidance, these Employees also may be called "On-going" Employees (meaning simply employees who are not new hires). This On-going Employee Measurement Period is the 12-month benefit eligibility verification period that applies to all Variable Hour Employees who are not new hires. This 12-month period generally ends within the 2 months prior to the annual health plan enrollment. Eligibility determinations based on calculations made for hours worked during this 12-month period will affect eligibility at the start of the Plan's next following Plan Year.

During each 12-month Measurement Period, all hours worked (as defined by federal law) are totaled for that specific employee for the entire 12-month period. That figure is divided by 12. If the resulting number is at or over 130, then that Employee is eligible for coverage as a Variable Hour Employee. Once eligibility has been established, the individual's eligibility shall continue for at least 12 months under federal rules stipulating operation of a benefit "stability" period. If the number is below 130, that Employee is not eligible for coverage as a Variable Hour Employee because he or she is not "Full-Time" as defined by federal law. Prior hours can be disregarded following a break in service of 13 weeks or more.

After a part-time Variable Hour Employee completes one benefit eligibility verification period (the new hire Measurement Period based on date of hire), the future eligibility of that part-time employee will then be considered using the 12-month benefit eligibility verification period that applies to all other Variable Hour Employees and which generally ends within the 2 months prior to the health plan enrollment period. The Plan shall designate that Measurement Period for on-going, non-new-hire employees on a consistent basis, and it is currently the timeframe noted in #2 above. Independent contractors are not eligible for Plan participation.

You are not eligible to participate in the Plan if you are:

- An independent contractor or a seasonal, temporary (through an agency) or leased employee
- Not treated as a common law employee on the City of Manchester's payroll records, even if a court or administrative agency subsequently determines you are a common law employee
- A member of any other special classification of employees that is not eligible, as determined by the City of Manchester.

Dependents of employees. As long as you enroll as an employee, you may extend Medical coverage to your eligible dependents. Your eligible dependents are generally defined as your:

- Lawful spouse
- Each child of you, your spouse through the last day of the month in which each child reaches age 26 (including stepchildren, foster children and adopted children, and those for whom you are the court-appointed guardian).

A child is considered legally adopted from the start of any waiting period prior to the finalization of the child's adoption; a newly born infant is considered legally adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption.

Note: Coverage for an unmarried child with a mental or physical handicap who is dependent on you for more than one-half of his/her support can continue to be covered without regard to age. Proof that the disability began before your child's 19th birthday, or if older, while covered as a dependent under the Plan, will be required.

Any eligible child you wish to enroll for coverage cannot be claimed as a dependent (as defined by the Internal Revenue Service (IRS)) on anyone else's federal tax return. If you are divorced or separated and applicable IRS rules permit both parents to provide tax-free health coverage, you may enroll your child.

In addition, the Plan may cover a child of yours in accordance with a Qualified Medical Child Support Order (QMCSO), to the extent that the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator (or its designee) will notify you if a medical child support order has been received and will notify both you and the affected child once a determination has been made. See "**Divorce and Your Benefits**" on page 20 for more information about a QMCSO.

When both husband and wife work for the City of Manchester. If you and your spouse both work for the City of Manchester, you may each enroll as employees, however, only one of you can enroll as a dependent of the other. In either case, children can only be enrolled under one parent's coverage. If either spouse works for the school district, you may each enroll as employees, however only one of you can enroll as a dependent of the other. In either case, children can only be enrolled under one parent's coverage.

Proof of dependent eligibility. The City of Manchester requires that all eligible employees enrolling in the Plan provide documentation (birth certificate or marriage license, for example) to validate the eligibility of their enrolled dependent(s) within 30 days of enrolling in the Plan. The City of Manchester may also periodically require proof of continued eligibility for a dependent.

If you fail to provide all of the required documentation within 30 days of enrolling in the Plan, the City of Manchester will terminate your enrolled dependents' coverage under the Plan whether or not they are eligible for benefits under the Plan. The City of Manchester also reserves the right to terminate enrolled dependents' coverage under the Plan for failing to provide required documentation at any time when requested.

Important Note Regarding Retiree Medical Coverage

Employees under age 65 who retire from the City of Manchester may continue Medical Plan coverage for themselves and their eligible dependents provided they pay the full monthly premium. Active employee contributions for Medical Plan coverage would continue through the last day of the month in which they are employed; retiree contributions (100% of total premium) would begin on the first of the month of their retirement. In certain cases, you may be eligible for a medical subsidy from the state retirement or city retirement plans, which can help offset the full cost of the premium.

When a retiree (or retiree's spouse) turns age 65, he or she has the option to enroll in the Plan offered by the City for retirees over age 65. The Plan becomes effective the first of the month in which he or she turns age 65. The retiree (or retiree's spouse) would also be required to enroll in Medicare Part B.

For more information about retiree health care coverage and eligibility requirements, please contact the Human Resources Benefits Coordinator at **1-603-624-6543**.

Enrolling for Coverage

Participation in Medical Plan coverage is not automatic; you must enroll in order to have coverage in place. When you are first hired, you will receive information outlining the Medical Plan options available to you, the cost per pay period for each option, enrollment instructions, and the due date by which your election(s) must be recorded.

It is important for you to know that if you do not enroll by the due date you will be considered to have declined Medical coverage for the remainder of the plan year. The next opportunity you will have to enroll is during the next annual enrollment period, unless you have a qualified change in status or "**HIPAA Special Enrollment Event**" as explained in "**Changing Your Elections During the Year**."

During annual enrollment. Each spring, the Plan Administrator will announce the open enrollment period during which time you will have an opportunity to change your Medical Plan election. Elections made during annual enrollment go into effect on July 1 of the following year, and stay in effect for that entire fiscal year, unless you have a qualified change in status during the year (see "**Changing Your Elections During the Year**") and you elect to make a change to your elections.

Changing Your Elections During the Year

The Plan Administrator will allow you to make changes to your elections each year during the annual open enrollment period with benefit elections becoming effective July 1 of the following fiscal year. If you are participating on a pre-tax basis, the IRS requires that your benefit elections stay in effect throughout the full Plan Year (July 1 through June 30) unless you experience a qualified change in status or HIPAA Special Enrollment Event, whichever comes first.

NOTE: If you are participating on an after-tax basis, please see "After-Tax Participation" on page 8 for more details.

What is a Qualified Change in Status Under Internal Revenue Code Section 125? The following events allow you to make changes to your Medical Plan coverage outside of the annual open enrollment period.

- A change in your legal marital status (for example, marriage, divorce, death of a spouse, legal separation, or annulment);
- A change in your number of eligible dependents due to birth, adoption, placement for adoption, appointment of legal guardianship, death, or when a dependent newly satisfies (or no longer continues to satisfy) the Plan's dependent eligibility rules;
- A change in your, your spouse's and/or your dependent's employment status, *but only if it affects your current elections*; for example, your beginning or ending employment, a reduction or increase in your hours that affects your eligibility, starting or returning from an unpaid leave of absence;
- A change in residence for you, your spouse, and/or your dependent, *but only if it affects your current elections*;
- Your being served with a Qualified Medical Child Support Order (QMCSO);
- You, your spouse, and/or dependent become eligible for Medicare or Medicaid;
- Change in coverage under another employer's plan;
- Change to other group health coverage for you, or your eligible dependents losing coverage under any government and/or educational institution sponsored group health plan.

Permissible types of benefit changes. Any change to your election(s) must be due to (and consistent with) your change in status. For example, if you have a baby during the year, you would be permitted to change your coverage option (e.g., from "Employee only" to "Two Person"). If you were to divorce, you must drop your ex-spouse's coverage however, you would not be able to change your coverage election (e.g., from an HMO to PPO). See the "**Life Status Coverage Changes**" chart on page 6 for more information.

Who determines what's permissible. The Plan Administrator (in its sole discretion) may determine whether your change in status is a qualifying event under the IRS regulations. The Plan may apply any change in status rule on a case-by-case basis in a uniform and consistent manner and without discrimination, and to the terms of any applicable insurance policy, where applicable. The application (or failure to apply) a change in status rule will neither limit nor prohibit the Plan Administrator's right to apply the rule on any subsequent occasion.

Initiating a change. You have 30 days from your qualifying change in status to modify your elections and submit your completed enrollment change and proof of status change documentation (birth or marriage certificates, for example). No exceptions allowed. To initiate your request to change your benefits or see a list of the acceptable supporting documentation, contact the Benefits Coordinator in the Human Resources Department. If you are initiating a change due to loss of coverage, your enrollment change form and documentation must be received within 60 days of the date of coverage loss.

Do not delay in submitting your completed enrollment request. Late notifications will only be accepted and processed during the next annual open enrollment period, or if you experience another qualified change in status (whichever comes first).

Effective dates of coverage for changes. In most cases, once the Plan Administrator approves your request to change coverage, it becomes effective in accordance with guidelines for life status changes.

The following chart provides an overview of qualifying change in status events and the mid-year elections permissible under the Plan for the related change in status event.

Status Change	Permissible Elections
Marriage	Enroll, increase level of coverage
Divorce, legal separation or annulment	Decrease level of coverage, or enroll self or dependents if HIPAA special enrollment rights apply (<i>see page 7</i>)
Add a dependent child	Enroll, increase or decrease level of coverage
Death of a spouse	Decrease level of coverage, enroll self or dependents if HIPAA special enrollment rights apply (<i>see page 7</i>)
Death of a child	Decrease level of coverage
Gain coverage through spouse	Decrease or cancel coverage; change level of coverage
Gain coverage through Medicaid or Medicare	Decrease or cancel coverage
Lose coverage through spouse's plan	Enroll for any plan and level or increase level of coverage in current plan
Lose coverage through Medicaid or Medicare	Enroll for any plan and level or increase level of coverage in current plan
If your spouse has a mid-year annual enrollment	Enroll, increase or decrease level of coverage in current plan, or cancel coverage
Child no longer eligible	Decrease level of coverage
Change from full-time or part-time with benefits to part-time <i>without benefits</i>	Cancel coverage
Change from part-time without benefits to full-time or part-time <i>with benefits</i>	Enroll
Significant increase in cost of coverage, a reduction in coverage, or a new plan option added	Decrease level of coverage and/or change plan
Change in status related to health care reform under the Affordable Care Act: <ul style="list-style-type: none"> ▪ Reduction in hours of service of eligible Variable Hour Employees 	Enrollment in another plan that provides minimum essential coverage effective no later than the first day of the second month following the month in which group health plan coverage is revoked
Change in status related to health care reform under the Affordable Care Act: <ul style="list-style-type: none"> ▪ Enrollment in a Qualified Health Plan through an Insurance Marketplace 	Enrollment in a Qualified Health Plan through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

HIPAA Special Enrollment Events. Under HIPAA, you are allowed to enroll in the Medical Plan under certain conditions including a “special enrollment” without having to wait until the next annual open enrollment period. To take advantage of a special enrollment, the following conditions must exist. You must also submit your completed request for enrollment to the Human Resources Benefits Coordinator within 30 days of the event. If you fail to complete and submit the appropriate enrollment forms within 30 days, you will need to wait until the next annual open enrollment, or when you experience a change in status, whichever occurs first.

Special Enrollment Under CHIPRA. Under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), if you or your dependent is eligible for (*but not enrolled in*) Medical coverage, you may enroll in this plan if:

- You or your dependent is covered under Medicaid or state Children’s Health Insurance Program (CHIP) and such coverage is terminated due to a loss of eligibility, provided you request coverage under the Medical Plan no later than 60 days after the Medicaid/CHIP coverage terminates; or
- You or your dependent becomes eligible for Medicaid or state CHIP, provided you request coverage under the Medical Plan no later than 60 days after you or your dependent is determined to be eligible for premium assistance.

If you are eligible, you or your dependent can request a special enrollment in the Medical Plan when:

- You have a newly acquired dependent as a result of marriage, birth, adoption (or placement for adoption); or
- There is a voluntary loss of other health coverage of any kind (including COBRA); loss of coverage does not include failure to pay premiums on a timely basis, termination of coverage for cause (making a fraudulent claim, for example), or you or your dependent’s voluntarily dropping coverage.

Conditions required to qualify for special enrollment.

- You are covered under another group health plan or other health insurance (including COBRA coverage) when the Plan was offered to you upon your initial eligibility period or during a subsequent open enrollment period; and
- You indicated during the enrollment process that you declined Medical Plan coverage because you already had other Medical Plan coverage.

If you meet both of these conditions, you will qualify for a special enrollment period if:

- Your other group health plan or other health insurance was terminated because you or your eligible dependents are no longer eligible for such coverage for any of the following reasons:
 - The Medical Plan you or your eligible dependents are enrolled in ceases to provide coverage to individuals who no longer reside or work in a service area and no other coverage option is available to you;
 - You or your eligible dependents’ employment terminates;
 - You or your eligible dependents have a reduction in hours worked;
 - Your spouse dies;
 - You and your spouse divorce or legally separate;
 - Your dependent loses his/or her eligibility status;
 - The City of Manchester (or your dependent’s employer) stops contributing toward coverage;

- The other plan terminates
- The other coverage was COBRA continuation and you or your dependent reaches the maximum length of time for COBRA continuation.

See “**Changing Your Elections During the Year**” on page 4 for additional information, including how to request a special enrollment and the effective date of a special enrollment.

Paying For Your Medical Coverage

You and the City of Manchester share the cost of any Medical coverage you elect for yourself and/or your dependents. If you elect to do so, your costs for any Medical coverage may be taken out of your paycheck on a **pre-tax basis**.

The City of Manchester will determine the level of Participant contribution for each type of coverage annually and will notify eligible employees and Participants in writing prior to each Plan Year as to what the Participant’s share of the cost will be for the upcoming Plan Year, for coverage for employees and their eligible family members, and will notify Participants in writing prior to any mid-year change in cost.

Notes:

- 1) When contributions are deducted from your paycheck on a **pre-tax basis**, the City does not withhold any federal income or Social Security taxes. This means you may pay less into Social Security and that your Social Security benefit could be slightly lower.
- 2) When contributions are deducted from your paycheck on an **after-tax**, the City withholds any federal income and Social Security taxes.

All employees are expected to pay their share of Plan premiums each payroll period. When an employee’s pay is insufficient to deduct the employee share of the premiums, missed premiums will be collected via payroll deduction in the next available paycheck. If an employee’s pay is insufficient for an extended period of time, then missed premiums will be due the first of the following month. If the employee fails to timely pay premiums coverage will be terminated, and in the case of any health coverage, continuation coverage generally will not be available if coverage is terminated due to non-payment. If an employee enrolls in health plan coverage but fails to pay the employee’s share of the premium on a timely basis, the Employer is not required to provide coverage for the period for which the premium is not timely paid, and the Employer is treated as having offered that employee coverage for the remainder of the coverage period (typically the remainder of the Plan Year) for purposes of Internal Revenue Code Section 4980H. As with premiums for COBRA continuation coverage under Q&A-5 of §54.4980B-8(a), (c), (d), and (e), the Plan provides a 30-day grace period for payment and also follows rules similar to COBRA (1) with respect to timely payments that are not significantly less than the amount required to be paid and (2) for responding to requests by health care providers for confirmation of coverage during the grace period. For more information about paying for your medical coverage, please contact the Benefits Coordinator in the Human Resources Department.

When Coverage Begins

As an eligible employee, you must be actively at work for one full day in order for coverage (or any increase in coverage) to begin. You are considered actively at work if you are performing your regular

duties. Medical coverage begins the first of the month following your date of hire, provided you submit your elections on a timely basis.

Dependents. Coverage for your enrolled eligible dependents normally begins at the same time your coverage begins. Dependents you acquire after you are first eligible may be enrolled for coverage as explained in “**Changing Your Elections During the Year**” on page 4. You have 30 days to enroll a newly-eligible dependent.

If you are rehired or reclassified into an eligible class for benefits. If you leave the City of Manchester and are subsequently rehired or reclassified into an eligible class for benefits, you will be eligible for coverage as of the first of the month following your rehire date (or date of reclassification). You must complete the enrollment process in order to have coverage in place. Any prior coverage you may have elected will **not** be automatically reinstated.

Pre-existing conditions. There are no pre-existing condition limitations on your Medical coverage.

What Happens During a Leave of Absence

If you take an approved leave of absence, you may be able to continue your coverage (even if your employment otherwise terminates) for up to the duration of the approved leave, but no longer than the maximum duration shown in the chart below. In order to qualify for this continued coverage, the leave must be authorized in writing, and you must continue to pay any applicable contribution or premium that you were paying before you began your leave. Failure to continue paying the applicable contribution will result in termination of coverage. If you are on an unpaid leave of absence, leave must be authorized in writing and you must pay the full premium (other than FMLA and Workers Compensation), in most instances. Contact Human Resources for questions regarding unpaid leave.

Type of Leave	Maximum Duration for Maintaining Benefits
Family Leave of Absence	Up to a maximum of 12 weeks in a 12-month period (<i>see following page for details</i>)
Personal Leave of Absence, Disability, or Other Qualified Leave	Throughout the period that employees continue to receive a paycheck; for details applicable to any unpaid leaves and benefits <i>see following pages 10 & 11 for reference</i>
Military Leave	up to 12 months (<i>according to the Military Leave of Absence Policy in effect at the time of your leave; see pages 10-11 for more details</i>)

Family Medical Leave Act of 1993 (FMLA) and Other Protected Leaves

Under the FMLA, you may be entitled to take up to a 12-week unpaid leave of absence from your job during a 12 month period if you need to care for a seriously ill family member, newborn baby, an adopted and/or foster child, or for your own serious illness, and be restored to the same or equivalent position upon your return from leave, provided you have worked for at least:

- 12 months; and
- 1,250 hours in the 12 months prior to your requested leave.

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave in a 12-month period for the employee’s own serious illness; the birth or adoption of a child; to care for a spouse, child, or parent who has a serious health condition; or to deal with any “qualifying exigency” that arises

from a family member's active duty in the Armed Forces (including the Reserves or National Guard). Additionally, an eligible employee may take up to 26 weeks of unpaid leave in a 12-month period to care for a "serious injury or illness" incurred by a family member wounded while on active duty in the Armed Forces. Contact Human Resources for more information regarding your entitlement to this leave.

While you are on FMLA or other qualified leave, you are entitled to continue or suspend group health coverage (Medical) for you and your eligible dependents. If you continue your participation, you must continue to pay your portion, if any, of the monthly cost of coverage or your benefits will be canceled. If you suspend your participation, benefit expenses incurred while you are on leave will not be covered under the Plan. You will have the right to be reinstated in group health coverage upon returning from FMLA or other qualified leave. Contact Human Resources for more information regarding your entitlement to this qualified leave.

If you elect to continue your group health coverage and do not to return to work at the end of the leave, you may be required to reimburse the City of Manchester for its portion of the cost paid towards maintaining your coverage during your leave. Exceptions may be considered if you cannot return to work because of a serious health condition or other circumstances beyond your control.

At the conclusion of your FMLA leave, you may be eligible for benefits under COBRA if:

- You or your enrolled dependents are covered on the day before the first day of FMLA leave or become covered during the FMLA leave under a group health plan;
- You do not return to work at the end of the FMLA leave; and
- Your or your enrolled dependent(s) would (in the absence of COBRA) lose coverage under the group health plan before the end of what would be the maximum coverage period (for example, you would no longer be covered under the same terms and conditions as those in effect for similarly situated active employee and their enrolled dependent(s))

Note: You will not be eligible for COBRA if the City eliminates group health plan coverage for active employees during your FMLA leave. See "**Applying for Continued Health Care Coverage Under COBRA**" for more details.

In certain circumstances, your leave of absence may exceed the amount of time for which you have protection under the FMLA. If this occurs, you are eligible to continue your participation in the Medical Plan provided you are covered by paid leave (sick or vacation) and continue to pay the employee contribution towards the cost of health care. You may be eligible to continue your participation in the medical plan if you are on unpaid status subsequent to the exhaustion of FMLA leave provided you pay the full contribution (employee and City of Manchester share). Assuming you are released to return to work within a prescribed period of time (and not administratively terminated), you have the right to be reinstated to the group health plan coverage, if you previously terminated coverage during the leave.

Benefit Coverages Available During An Unpaid Leave of Absence

The City of Manchester continues to pay its share of the Health and Dental Insurance contribution during the period an employee is on Family Medical Leave (FMLA) or Worker's Compensation (WC). If the employee is not being paid by the City during this period, the employee is responsible for paying the employee's portion of his health and dental contribution and any Optional Disability and Life Insurance premiums during that period of unpaid FMLA or Worker's Compensation leave. It is the employee's responsibility to submit payment directly to the City of Manchester. Failure to do so can result in loss of coverage.

The City of Manchester does not continue to pay its share of the Health and Dental Insurance contribution during the period that an employee is granted an Unpaid Leave of Absence (other than FMLA or WC) that extends one full calendar month or longer. The employee is responsible for monthly payments in full if he/she wishes to continue to be enrolled in any City's benefits.

Unpaid Leave of Absence, for any other reason (excluding FMLA and WC), that results in an unpaid status for a full calendar month, requires payment of the full cost of health, dental and optional life and disability insurance premiums for that month and any subsequent full calendar months of unpaid leave. It is the responsibility of the employee to submit payments directly to the City of Manchester. Again, failure to do so can result in loss of coverage.

Military Leaves of Absence

Short Term Military Leave. If you enter the armed services (including the Reserves or National Guard), you may be entitled to continue your eligible dependents' coverage under the Plan during your military service during the entire period of activation. If you are absent from work due to military service for a period of 31 days or less (a "short term" military leave), your Medical Plan coverage will continue during your short-term military leave.

Contributions for any Medical Plan coverage that remains in effect will be the same as those for any similarly situated active participants in the plan. When you return to work, you must pay your portion, if any, of the premium for any coverage that continued during your short-term military leave.

Long Term Military Leave. When an employee is deployed on long term military leave (more than 31 days), the following policy will be adhered to in terms of benefits.

- If the employee is on a single plan, coverage is suspended and no premiums are paid until the employee returns from deployment. Military provides health and dental coverage while on deployment
- If the employee is on a two person or family plan, coverage will remain in effect and 100% of the premiums will be paid by the City of Manchester, per the Board of Mayor and Aldermen vote of April 6, 2010.
- Per UNUM, Basic Life and LTD will remain in effect for 1 year when an employee is deployed on military leave. Premiums will continue to be paid by the City of Manchester
- Per UNUM, supplemental life and LTD will cease upon lapse of coverage (nonpayment) and employee will need to reapply when they return to work.

When Coverage Ends

Your (and your eligible dependents) participation in Medical Plan coverage ends on the earliest of any of the following events:

- The date you (or they) are no longer considered an eligible employee (or dependent) as described on page 1;
- The last day of the month you are actively at work (except as provided under the approved leave of absence provisions described on page 9);
- The date you stop making any required contributions toward the cost of your and/or your eligible dependents' coverage;
- The date the City of Manchester no longer covers your class of employees or eligible dependents; or
- The date the City of Manchester stops offering the Plan.

Medical Plan coverage continues to the end of the month in which you or dependents' eligibility ends (as applicable), or longer as described below.

Extended coverage. You may continue coverage beyond the time it would otherwise normally end by electing COBRA, as explained below.

Applying for Continued Health Care Coverage under COBRA

What is COBRA Continuation Coverage? You (and in some cases, your eligible dependents) may have the right to continue participation in health care coverage when you would otherwise lose such coverage, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You can extend coverage up to 18 months or in some cases up to 36 months as described below. If you qualify, you can continue your Medical Plan coverage if you were previously enrolled.

In order to qualify for COBRA continuation coverage you must have a “qualifying event” that would otherwise end your coverage. Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. (Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders [QMCSOs] may also be qualified beneficiaries).

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including annual open enrollment and special enrollment rights. Specific information describing the coverage to be continued under the Plan is contained elsewhere in this notice. For more information about your rights and obligations under the Plan, you can get a copy of additional information from the COBRA or Plan Administrator.

When is COBRA Coverage Available? The Plan offers COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, or death of the employee, the City will notify the COBRA Administrator of the qualifying event.

Qualifying Events Applicable to Active Employees. If you are an employee, you will become a qualified beneficiary if you will lose your Medical Plan coverage because one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Qualifying Events Applicable to Spouses. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse.

Qualifying Events Applicable to Dependent Children. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated, or;
- The child stops being eligible for coverage under the plans as a "dependent child."

Children who are born to or placed for adoption with a covered employee during the period of the employee's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

The COBRA Administrator. Benefit Strategies is the Plan's COBRA Administrator. For any purposes of notification, you may contact them at:

Benefit Strategies, LLC
 967 Elm Street
 Manchester, NH 03102
 Phone: 1-603-647-4666
 Fax: 1-603-647-4668

You Must Give Notice of Some Qualifying Events. For certain qualifying events (i.e., divorce or legal separation of you and your spouse, or a dependent child losing eligibility for coverage as a dependent child), you (or your family member) must notify the Plan Administrator within 30 days after the later of the date the qualifying event occurs or the date of the loss of coverage due to the qualifying event. The notice must be in writing and must be sent to Human Resources. The notice must include the name of the employee, the name(s) of the qualified dependent(s), the type of qualifying event (for example, divorce), and the date of the qualifying event. If the qualifying event is divorce or legal separation, you must submit a copy of the final divorce decree, "Notice of Decision" or written proof of the legal separation.

The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

How to Elect COBRA Continuation Coverage. After the COBRA Administrator has received notice of the qualifying event from the Plan Administrator, the COBRA Administrator will send a COBRA notification to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Qualified beneficiaries have 60 days from the later of the date:

- Of the loss of coverage because of the qualifying event, or;
- They receive a COBRA Election Notice, to elect COBRA continuation coverage.

Election forms must be post-marked within that 60-day period and must be received by the COBRA Administrator.

For each qualified beneficiary who timely elects and pays for COBRA continuation coverage, coverage will begin on the date that coverage under the Plan would otherwise have been lost due to the qualifying event. If you timely elect (and pay for) COBRA continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If you do not timely elect (and pay for) COBRA continuation coverage, your health coverage under the Plan will end.

IF YOU OR YOUR DEPENDENTS DO NOT PROVIDE A NOTICE OF A QUALIFYING EVENT TO THE PLAN ADMINISTRATOR BY THE END OF THE 60-DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.

Special Note. In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. Finally, instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace or Medicaid. Some of these options may cost less than COBRA continuation coverage. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Cost of COBRA Coverage. As provided by law, you and/or your covered dependents must pay the full premium cost of coverage plus 2% for administrative expenses for the full 18- or 36- month period. In cases of extended continuation coverage due to disability, the cost for months 19 to 29 is 150% of the full premium cost for the coverage. The COBRA Administrator will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage and will also notify you of any changes in the monthly COBRA premium amount.

Paying for COBRA Continuation Coverage. You must send the initial payment for COBRA coverage to the COBRA Administrator within 45 days of the date you choose COBRA coverage (a U.S. Post Office postmark will serve as proof of the date you sent your payment). You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end). If you do not make this payment within 45 days of the date of your COBRA election, you (and your family members) will not be entitled to COBRA continuation coverage.

After the initial premium payment, monthly premium payments are due on the first day of each month, and there will be a grace period of 30 days each month to make these payments. If you fail to pay by the end of the grace period, your (and your family's) coverage will cease as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, your payment must be sent and postmarked by the U.S. Post Office on or before the last day of the grace period and must be received by the COBRA Administrator. A check that has been returned unpaid from the bank for any reason may result in untimely payment and can result in cancellation of coverage.

How Long Does COBRA Continuation Coverage Last? COBRA continuation coverage is a temporary continuation of coverage. The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage.

Qualifying COBRA Events		
If You Lose Coverage Because:	These People Would Be Eligible:	For COBRA Coverage For Up To:
Your employment terminates	You and your eligible dependents	18 months
Your working hours are reduced	You and your eligible dependents	18 months
You are determined to be disabled by the Social Security Administration	You and your eligible dependents	29 months
You die	Your dependents	36 months
Your marriage is civilly annulled	Your dependents	36 months
You divorce or legally separate	Your dependents	36 months
Your dependent children no longer qualify as dependents	Your dependent children	36 months
You are retired and you become entitled to Medicare benefits	Your dependents	36 months

If the qualifying event is the end of your employment or reduction in your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of 18-month COBRA coverage period for Social Security Disability. If you or any enrolled dependent is determined by the Social Security Administration (SSA) to be disabled for Social Security disability purposes at some time before the 60th day of COBRA continuation coverage, you may continue coverage for an additional 11 months, up to a maximum of 29 months, from your original qualifying event date. The cost of this extended coverage will be increased to 150% of the full premium cost. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension.

You must inform the COBRA Administrator of your disability in writing within 60 days of the later of:

- The date of the Social Security Administration's disability determination letter;
- The date on which your qualifying event occurred, or;
- The date on which the qualifying beneficiary lost coverage as a result of the qualifying event.

In addition, you must notify the COBRA Administrator in writing before the end of your 18-month period of continuation. Be sure to enclose a copy of the Social Security disability determination letter. If you do not notify the COBRA Administrator within the timeframes stated above, you will not qualify for this extension.

Extension of 18-month COBRA coverage period due to a second qualifying event. If your spouse or dependents have another qualifying event while receiving COBRA continuation coverage because of your

termination of employment or reduction in hours, your spouse and dependent children may elect additional COBRA coverage, up to a maximum of 36 months, if proper notice is provided to the COBRA Administrator. This extension is available to your spouse and dependent children if you die or get divorced or legally separated or become entitled to Medicare (Part A, Part B or both). The extension is also available to a dependent child when he or she stops being eligible under the plan as a dependent child. In all of these cases, you must notify the COBRA Administrator of the second qualifying event within 60 days after the second qualifying event. If you do not notify the COBRA Administrator in writing within the 60-day period, you will not qualify for this extension.

Acquiring New Dependents While Covered By COBRA. Children who are born to or placed for adoption with a former covered employee during the period of the employee's continuation coverage are qualified beneficiaries and are entitled to COBRA continuation coverage for the same maximum period as the other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse to your coverage while you are on COBRA continuation coverage, but the new spouse is not thereby a qualified beneficiary. In order to add a newly acquired dependent, you must notify the COBRA Administrator within 30 days of the marriage, birth or placement for adoption and pay the required premium within 45 days of returning your election form. You must include payment for all months retroactive to the date you acquired the dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the COBRA Administrator for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage. If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

You should enroll the spouse or dependent within 30 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Losing COBRA Coverage. COBRA coverage will end sooner than shown on the chart (page 14) on the occurrence of any of the following events:

- The date, after the date of the COBRA election, on which you or your eligible dependent become entitled to coverage under Medicare (Part A, part B, or both) or another group health care plan;
- The first day of the time period for which you do not pay the COBRA premiums on time;
- The date on which the City stops providing these benefits to employees;
- Coverage has been extended for up to 29 months due to disability and there has been a final Social Security Administration determination that the individual is no longer disabled. In this case, coverage will end as of the

month that begins more than 30 days after the date of such final determination; you are required to notify the COBRA Administrator in writing within 30 days of any such final determination;

- Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving the continuation coverage (such as fraud).

Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You also should keep a copy of any notices you send to the Plan Administrator.

For More Information

It's important to keep in mind that this section provides a general description of the eligibility and participation provisions that apply to the Plan. If you have any questions regarding your own situation, you are encouraged to call the Human Resources Benefits Coordinator at **1-603-624-6543**.

Important Note about other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Through the Market Place, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Administrative Information

No Continued Right to Employment

Being a participant in any of the benefit options under the Plan does not give you any right of continued employment with the City of Manchester.

Maternity/Newborn Coverage – Newborns’ and Mothers’ Health Protection Act (NMHPA)

This applies whether or not the group health plan documents in Appendix A include such provision. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act of 1998 (WHCRA)

This applies whether or not the group health plan documents in Appendix A include such provision. The WHCRA requires a group health plan to notify you, as a participant or beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for (a) all stages of reconstruction on the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and (d) treatment of physical complications of the mastectomy, including lymphedema. This coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your benefits booklet or contact Human Resources.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of the Health Insurance Portability and Accountability Act (HIPAA), generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual’s family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

How Benefits Can Be Forfeited or Delayed

While the Claims Administrator is committed to paying claims promptly, you may forfeit or delay reimbursement of eligible expenses or claims if:

- You or your beneficiary do not properly file a claim within the time period required;

- You do not furnish information or supporting documentation required to complete or verify your claim; or
- Your current address is not on file with the City or the Claims Administrator.

You should also be aware that reimbursements are not payable for dependents that become ineligible due to age or change in marital status. Finally, you should know that benefits may be lost if they were described or paid to you in error or were not authorized by the Claims Administrator.

Compliance With Federal Law

The Medical Plan is governed by guidance issued by the Internal Revenue Service and the Department of Labor, and current tax and federal law. The Medical Plan will always be construed to comply with the guidelines and laws currently in effect.

Applicable state law. Generally, federal law pre-empts (that is, takes precedence over) state law. However, in any situation where state law is not pre-empted and the applicable state law is not specified in the Plan document, then the statutory and common law of the State of New Hampshire will apply, including its statute of limitations and other substantive and procedural law, but not including its choice of law provisions.

Ownership of Benefits

The benefits described here are exclusively for eligible City of Manchester employees or their properly designated beneficiaries and, if applicable, their enrolled dependents. It is a condition of the Plan, and all rights of each Participant and beneficiary shall be subject thereto, that no right or interest of any Participant or beneficiary in the Plan and no benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any action by way of anticipating, alienating, selling, transferring, assigning, pledging, encumbering, or charging, the same shall be void and of no effect; nor shall any such right, interest or benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such right, interest or benefit, except as specifically provided in this Plan or in the applicable insurance contract.

Subrogation and Third-Party Reimbursement

As a condition to receiving benefits from the Plan, you (the "Participant") acknowledge and agree to the following, if the Participant is injured through the acts or omissions of a third party:

- Should the Participant seek to recover any monies from the third party that caused the injuries, the Participant must give notice to the Plan Administrator within ten (10) days after either the Participant or the Participant's attorney first attempts to recover such monies, and if litigation is commenced, the Participant is required to give notice to the Plan Administrator of any pretrial conferences within five (5) days of the same. Representatives of the Plan reserve the right to attend such pretrial conference.
- By accepting benefits from the Plan, the Participant agrees to timely comply with any and all requests from the Plan for documentation concerning any legal proceedings, settlement negotiations and/or medical information that may give rise to or affect the Plan's right to subrogation and/or restitution. The Plan will be subrogated to any and all claims, demands, actions and rights of recovery of the Participant against the third party. The Participant will furnish such information and assistance and execute and deliver all necessary instruments as may be required to facilitate the enforcement of the Plan's subrogation rights and will refrain from any acts that might prejudice those rights. Any Participant, in accepting any benefits provided by the

Plan, represents and covenants that no release has been or will be given in settlement or for compromise with any third party who may be liable in damages to the Participant without the express written consent of the Plan.

- The Plan's lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his insurance carrier and/or any other party settling on his behalf. By applying for and receiving benefits from the Plan in such third party situations, the Participant agrees to restore to the Plan the full amount of the benefits that are paid to the Participant and/or the Participant's dependents from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law.
- Any amounts received from the third party must be applied first to reimburse the Plan for the amount of benefits paid to or on behalf of the Participant. The Plan's right to reimbursement takes priority over the Participant's right of recovery, regardless of whether or not the Participant has been made whole for his or her injuries or losses. The Plan does not recognize and is not bound by any application of the "make whole" doctrine. The Plan will have first priority in any recovery regardless of how the recovery is structured (e.g., even if the recovery purports to be for damages or expenses other than medical expenses).
- The Plan's reimbursement will not be reduced by attorney's fees, court costs or disbursements that the Participant might incur in an action to recover from the third party, and these expenses may not be used to offset the Participant's obligation to reimburse the Plan for the full amount of benefits paid.
- In the event the Participant fails to reimburse the Plan out of any recovery made from the third party, then, upon 30 days' notice to the Participant, the Plan may suspend future payments until full reimbursement is received by the Plan or offset future payment amounts that would otherwise be paid to the Participant.
- The Plan's right to reimbursement and subrogation right extends to any auto insurance coverage that provides the Participant's uninsured or underinsured auto insurance coverage.

The Plan does not require the Participant to seek any recovery whatsoever against the third party, and if the Participant does not receive any recovery from the party, the Participant is not obligated in any way to reimburse the Plan for any of the benefits that the Participant applied for and accepted.

Divorce and Your Plan Benefits

In the event of a divorce, your ex-spouse must be removed from your insurance the 1st of the month following the date the judge signed the final "Notice of Decision".

In the event of a divorce or a child support court order, benefits may be payable to someone other than you and/or your designated beneficiary, if a Qualified Medical Child Support Order (QMCSO) is issued by the court. The Plan Administrator will determine whether the order is "qualified."

New Hampshire state law requires group health plans to honor QMCSOs. In general, QMCSOs are state court orders requiring a parent to provide medical support to a child – for example, in cases of legal separation or divorce.

A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child does not reside with you and is not claimed as your dependent on your federal tax return. In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your last known name and address, and the child’s name and last known address;
- Provides a reasonable description of the type of coverage to be provided by the Plan, or the manner in which the type of coverage is to be determined;
- States the period to which it applies; and
- Specifies each plan to which it applies.

A state child support enforcement agency may obtain group health coverage for a child by issuing a medical support notice.

The QMCSO may not require the Plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan. Upon approval of a QMCSO, the Plan is required to pay benefits directly to the child, or to the child’s custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the Plan.

You and the affected child will be notified if an order is received and will be provided with a copy of the Plan’s QMCSO procedures free of charge. A child covered under the Plan pursuant to a QMCSO will be treated as an eligible dependent under the Plan.

Plan Administration

The Claims Administrator and the Plan Administrator all play a role in supervising the Plan.

- **Human Resources** is responsible for routine administration, such as answering questions concerning eligibility, coverage and administration, and providing basic information about the plans.
- **The Claims Administrator** has sole and absolute discretionary authority to determine whether you have incurred a covered expense for which benefits may be payable under the Plan and to determine the amount, and administer the payment, of any such benefits under the Plan. (See “**Plan Facts**” beginning on page 23 for identification of the Claims Administrator.)
- **The Plan Administrator** (City of Manchester) has the authority to evaluate a claim related to your eligibility to participate in the Plan and to evaluate a claim, other than directly related to determining whether you have incurred a covered loss or expense for which benefits are payable under the Plan. The Plan Administrator also has the authority to decide certain voluntary appeals of the Claims Administrator’s decisions that can occur through the Medical Plan.

The Plan Administrator (or its designee) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator (or its designee), shall have the sole and absolute discretionary authority:

- To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- To formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

- To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
- Except as provided to the contrary under the Plan, the governing documents and applicable law, to process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or its designee) with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. If any such determination shall involve a question of law, the Plan Administrator (or its designee) may rely and act upon the advice of counsel with respect thereto.

All claims should be directed to the applicable administrator (either the Claims Administrator or the Plan Administrator) and the entire claims procedure and appeals process, as described in each portion of this Plan, will be handled through that administrator. Please refer to your Subscriber Certificate for more information on filing a claim for benefits.

You will find that most of your questions regarding the Plan can be answered by the Claims Administrator or the Human Resources Department.

If conflicts arise. The City of Manchester and the Claims Administrator will always try to give you the most complete and accurate information regarding the Plan. Should there be a discrepancy between what is conveyed to you and the terms of the Plan document, federal law requires that the Plan documents always control. Depending on the nature of your issue, the Plan Administrator or the Claims Administrator, using the Plan documents, will make the final determination.

Additional administrative information. The Plan Administrator may delegate its responsibilities among employees of the City of Manchester and may consult with or hire outside experts. The Committee is designated by the Board of Mayor and Aldermen of the City of Manchester (the "Board"). Further, the Human Resources Director has authority to execute governmental filings or other documents relating to the Plan. This authority may also be delegated to employees of the City of Manchester by the Board of Mayor and Aldermen.

Any discretionary actions to be taken under the Plan by the City with respect to the classification of the Participants, contributions, or benefits shall be uniform in their nature and applicable to all Participants similarly situated. With respect to service with the City of Manchester, leaves of absence and other similar matters, the City of Manchester shall administer the Plan in accordance with the regular personnel policies in effect at the time.

Future of the Plans

The City of Manchester has every intention of continuing the Plan indefinitely, but reserves the right to change, terminate, suspend, withdraw, reduce, amend or modify the Plan at any time, in any manner, at the City of Manchester's sole discretion, according to the procedures set out in the official plan documents. Any change or termination of benefits will be based solely on the decisions of the City of Manchester and may apply to active employees, dependents of employees, early retirees and participants covered through COBRA, as either separate groups or as one group. You will be notified of any change; however, the change may be effective before any notice is delivered to you.

Plan amendments. Plan amendments will be made by action of the Plan Administrator (or its designee). In addition, premium and contribution rates may change from year to year, as determined by the Plan Administrator.

Plan Facts

Plan Name:	City of Manchester Health and Welfare Plan
Plan Number:	Refer to page 24 for respective plan numbers
Plan Sponsor:	City of Manchester One City Hall Plaza Manchester, NH 03101 1-603-624-6543
Employer Identification Number:	02- 6000517
Plan Administrator:	City of Manchester One City Hall Plaza Manchester, NH 03101 1-603-624-6543
Agent for Service of Legal Process:	Process may be served upon the Plan Administrator at the address indicated above.
Plan Year:	July 1 – June 30
Type of Plan:	Welfare benefit plan providing the following types of coverage: <ul style="list-style-type: none">• Medical and Prescription Drug• Dental• Basic Life Insurance• Accidental Death and Dismemberment• Long Term Disability / EAP• Health Care Flexible Spending Account (HCFA)• Dependent Care Reimbursement Account (DCRA) The Plan also includes a cafeteria plan under Code Section 125. The cafeteria plan is not subject to ERISA.
Claims Procedures:	Information will be found in the materials listed in Addendum A and incorporated by reference herein.
Type of Administration:	Insurer and/or Third Party Administrator
Type of Funding:	City of Manchester and Employee Contributions

Addendum A Participant Certificate of Coverage

Plan Administration / Incorporated Benefit Documents Effective as of July 1, 2020

Benefits are administered according to the terms of the applicable insurance policies, administrative contracts and plan documents. The following documents are incorporated by reference into this Wrap-Around Plan Document and Summary Plan Description as if reproduced in full herein. The relevant documents below describe the extent to which the benefits under this Plan are guaranteed under a contract or policy, the nature of administrative services provided the eligibility and enrollment requirements, and the claims procedures.

All documents referenced in this appendix are available on request by contacting Human Resources during normal business hours at: City of Manchester, Human Resource Department, One City Hall Plaza, Manchester NH 03101; Phone: 1-603-624-6543; Website: www.manchesternh.gov/benefits

Carrier Contact Information and Benefit Type	Document	URL/Web Address
Medical - <u>Self-Funded</u> Carrier Name: Anthem Address: 1155 Elm St, Suite 200, Manchester, NH 03101 Phone: 1-888-224-4896	Firm # 358279	www.anthem.com
Dental - <u>Self-Funded</u> Carrier Name: Delta Dental Address: 1 Delta Drive, Concord, NH 03301 Phone: 1-800-832-5700	Group # 3203	www.nedelta.com
LIFE/ AD&D – <u>Fully Insured</u> Carrier Name: Unum Office Address: 2211 Congress Street, Portland, ME 04122 Phone: 207-575-2211	Policy # 910591	www.unum.com
LTD / EAP– <u>Fully Insured</u> Carrier Name: Unum Office Address: 2211 Congress Street, Portland, ME 04122 Phone: 207-575-2211	Policy # 910591	www.unum.com
Flexible Spending Accounts – <u>Self-Funded</u> Carrier Name: Benefit Strategies Address: 967 Elm St, Manchester NH 03101 Phone: 1-888-401-3539	Flexible Benefit Plan Flexible Benefit SPD	www.benstrat.com

A. Fully-Insured. The vendors listed above for coverages indicating fully-insured status provide benefits under one or more insurance policies or contracts issued to the Plan Sponsor. These vendors are solely responsible for financing and providing the benefits under the insurance policies and contracts. The Plan Sponsor has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

B. Self-Funded. The vendors listed above for coverages indicating self-funded status provide certain administrative services for the self-funded coverages. These vendors provide claims payment and other administrative services under an administrative services contract with Plan Sponsor but they do not assume any financial risk or obligation with respect to claims or benefits under the coverages.

Addendum B Eligible Employees

Plan Administration / Incorporated Benefit Documents

Effective as of July 1, 2020

For Medical, Pharmacy, Dental, Life, Long Term Disability and Flexible Benefit Plan

For the Plan Year in which health reform takes effect and for the future, the Plan intends to administer eligibility using current guidelines permitted under federal health reform and all health reform eligibility guidance yet to be issued. All provisions herein shall be interpreted such that the Plan shall be in compliance with those rules and guidelines. Any minor inconsistencies shall be automatically revised to be in compliance with those rules and their interpretations by the federal agencies.

For Medical

To participate in the Medical and Pharmacy coverage, an Employee must meet the eligibility requirements as follows: First of the month following date of hire.

As defined for purposes of the Employer Shared Responsibility Provisions under the Affordable Care Act, as of January 1, 2015:

Full-Time Employees (not otherwise classified above). “Full-Time” is defined as an employee working thirty (30) or more hours a week on average in a month, which is considered to be one hundred thirty (130) hours in the course of a month.

Employees in positions who are expected or designated to be Full-Time based on expected work hours at date of hire are eligible for the Plan. Under federal law, health plan coverage will begin no later than ninety (90) days from the hire date. Other benefits’ effective dates are not impacted. From time to time, a shorter waiting period may apply or different standards for waiting periods may apply relating to (1) bona fide orientation periods for new hires, (2) required hours up to 1,200 hours for new hires, (3) hours bank requirements, and (4) such other variations to the hours or term of employment as allowed by federal law, agency interpretations, or other clarifications to the waiting period rules under federal health reform, including but not limited to as a result of court decisions.

Part-time, Variable Hour and Seasonal Employees (not otherwise classified above). Employees in part-time status expected to be working less than 30 standard hours per week, with hours that will vary, and who are expected/designated to be “Variable Hour Employees” are ineligible for participation until the City of Manchester makes a determination of eligibility based on hours actually worked or credited under the law. That determination is made following a 12-month benefit eligibility verification period, or “Measurement Period.” Similarly, Seasonal Employees will be subject to the determination of eligibility based on hours actually worked or credited under the law. A Seasonal Employee for this purpose is an individual hired for a position that is customarily filled at around the same time every calendar year and which generally is of less than 6 month’s duration. Seasonal status will be designated using processes

similar to those for Variable Hour Employees.

Determination of that status and/or eligibility for 2015 and beyond will be based on current designation of employment status as full-time or on hours worked for Full-Time Employees and Variable Hour Employees, respectively, in accordance with current federal law. (Seasonal Employees will be treated similarly to Variable Hour Employees.) To the extent the City of Manchester wishes to use a federal agency interpretation of these requirements to determine hours, status, Plan eligibility, or otherwise, the City of Manchester may choose to do so to the fullest extent of the law, including special short-term rules which permit determinations of employer size and/or eligibility on the basis of period of less than a full 12 months or calendar year or Plan Year.

Two separate Measurement Periods are used for Variable Hour and Seasonal Employees, one for new hires that is specific to the date of hire of that particular Employee, and one for all other Variable Hour or Seasonal Employees (in other words, those who are not new hires).

- 1. New Hire Measurement Period.** For a new hire, the New Hire Measurement Period shall be 12 months starting with the first of the month following date of hire, allowing for the person's information to be entered into employment and hours systems. Hours worked are counted beginning the first of the month following date of hire through the following 12-month period. Eligibility determinations based on calculations made for hours worked during this 12-month period will affect eligibility for the Plan for the 12-months starting with the 13th month following date of hire. In other words, if a new hire is determined to be a Full-Time Variable Hour (or Seasonal) Employee, the Employee will be eligible to participate in the Plan beginning with the first day of the 13th month following date of hire.
- 2. On-Going Employee Measurement Period.** For On-going Employees (other than new hires) who work Variable Hours or who are Seasonal, the On-going Employee Measurement Period shall be 12 months from May 1st to April 30th. In other Plan materials or in federal publications and guidance, these Employees also may be called "On-going" Employees (meaning simply employees who are not new hires). This On-going Employee Measurement Period is the 12-month benefit eligibility verification period that applies to all Variable Hour Employees who are not new hires. This 12-month period generally ends within the 2 months prior to the annual health plan enrollment. Eligibility determinations based on calculations made for hours worked during this 12-month period will affect eligibility at the start of the Plan's next following Plan Year.

During each 12-month Measurement Period, all hours worked (as defined by federal law) are totaled for that specific employee for the entire 12-month period. That figure is divided by 12. If the resulting number is at or over 130, then that Employee is eligible for coverage as a Variable Hour Employee. Once eligibility has been established, the individual's eligibility shall continue for at least 12 months under federal rules stipulating operation of a benefit "stability" period. If the number is below 130, that Employee is not eligible for coverage as a Variable Hour Employee because he or she is not "Full-Time" as defined by federal law. Prior hours can be disregarded following a break in service of 13 weeks or more.

After a part-time Variable Hour Employee completes one benefit eligibility verification period (the new hire Measurement Period based on date of hire), the future eligibility of that part-time employee will then be considered using the 12-month benefit eligibility verification period that applies to all other Variable Hour

About Your Participation Revised October 8, 2020

Employees and which generally ends within the 2 months prior to the health plan enrollment period. The Plan shall designate that Measurement Period for on-going, non-new-hire employees on a consistent basis, and it is currently the timeframe noted in #2 above. Independent contractors are not eligible for Plan participation.

Flexible Spending Account and Dependent Care Reimbursement Account

To participate in the Flexible Spending Account and Dependent Care Reimbursement Account plans, an Employee must meet the eligibility requirements as follows: First of the month following the date of hire.

Dental

To participate in the Dental coverage, an Employee must meet the eligibility requirements as follows: First of the month following three full calendar months of full time status of continuous employment.

Life, Supplemental Life AD&D, and LTD

To participate in the Life, AD&D and LTD coverage, an Employee must meet the eligibility requirements as follows:

- First of the month following the date of hire. For Life benefits, must be scheduled to work 20 hours. For Supplemental Life, you may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.
- For LTD benefits full time status scheduled to work 30 hours per week.

Employee Assistance Plan (EAP) provided by Health Advocate through Unum

Same as LTD eligibility

Eligible Employee - Shall not Include

You are not eligible to participate in the Plan if you are:

- A temporary and seasonal employee
- An independent contractor or a temporary agency or leased employee.

- Not treated as a common law employee on the City of Manchester's payroll records, even if a court or administrative agency subsequently determines you are a common law employee. A member of any other special classification of employees that is not eligible, as determined by the City of Manchester.

Addendum C: HIPAA Privacy & Security Rule

The Plan and City of Manchester will comply, as required by law, with the HIPAA Privacy and Security provisions of current federal law, including but not limited to compliance with individuals' requests for certain restrictions on disclosure of their PHI or ePHI, increased obligation to account for disclosures of ePHI if maintained in electronic health records, increased access to PHI maintained in electronic format, and required notification of breaches of "unsecured" PHI where the unauthorized person who received the PHI might reasonably be able to retain the information.

This is a general Notice of Privacy Practices under HIPAA. You may also receive a Notice of Privacy Practices from the third party administrator who administers your health benefits under this Plan. The specific Privacy Notice(s) you receive from your third party administrator will take precedence over this general Notice, if there is any conflict between the two Notices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: This privacy notice is effective July 1, 2020.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Dental
- Health FSA
- Dependent Care Reimbursement Account
- EAP –provided by Health Advocate through Unum

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and

- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and

general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of the Plan Sponsor. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for

example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you

with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at Human Resources or by calling (603) 624-6543. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at Human Resources or by calling (603) 624-6543.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at Human Resources or by calling (603) 624-6543.

Electronic Health Information

There are also some special rules under HIPAA related to “electronic health information.” Electronic health information is generally PHI that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, the City of Manchester will take additional action with respect to the implementation of security measures (as defined in 45 C.F.R. § 164.304) for electronic PHI. Specifically, the City of Manchester will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation required to exist between the Plan and the City of Manchester is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and

- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or other guidance pursuant to HIPAA.